MONTANA PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION
100 N PARK AVE STE 200 ~ PO BOX 200131
HELENA MT 59620-0131
406-444-3154 or toll free 877-275-7372

ELECTION TO QUALIFY ABSENCE

To receive service credit for an absence covered under Workers' Compensation.

Name_____ SS#_____

Dates of Absence – From _____to_____

My employer has advised that I may make contributions for the above absence and receive service credit.

_____ I DO NOT WISH TO PURCHASE THIS SERVICE.
(INITIALS)

_____ I DO WISH TO PURCHASE THIS SERVICE - PLEASE PROVIDE THE COST.
(INITIALS)

Signature of Member _____Date_____

Mailing Address _____

City, State, Zip _____

EMPLOYER CERTIFICATION - REQUIRED:

If the employee elects to purchase this service, *you must certify the compensation and hours this employee would have earned and worked, if not for the work related absence*. A certification form is attached. Reference §§ 19-3-504, 19-6-810, 19-7-810, 19-8-905 MCA.

Employing Agency _____

Contact Person _____

Mailing Address _____

City, State, Zip _____

Payroll Clerk/Certifying Official's Signature_____

Telephone Number_____ Date_____

ATTENTION: This form must be submitted to MPERA within one year of the employee returning to work. You should retain a copy for your records and forward the original to the MPERA.

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CERTIFICATION OF WORKERS' COMPENSATION ABSENCE

NAME_____EMPLOYER_____

From_____ through_____

Certify the actual compensation, by month, paid to the above employee. Certify the compensation the employee would have received if not for the workers' compensation absence. Specify the total hours missed by month, due to the workers' compensation absence.

	Year: _____				Year: _____			
	COMPENSATION RECEIVED	WOULD HAVE RECEIVED	DIFFERENCE	HOURS	COMPENSATION RECEIVED	WOULD HAVE RECEIVED	DIFFERENCE	HOURS
JAN								
FEB								
MAR								
APR								
MAY								
JUN								
JUL								
AUG								
SEP								
OCT								
NOV								
DEC								
TOTAL								

I certify the above compensation and hours accurately reflect the payroll records of this agency.

_____ _____ _____
Name of Payroll Clerk/Certifying Official Telephone Number E-mail Address

_____ _____
Signature of Payroll Clerk/Certifying Official Date